МІНІСТЕРСТВО ОХОРОНИ ЗДОРОВ'Я УКРАЇНИ
БУКОВИНСЬКИЙ ДЕРЖАВНИЙ МЕДИЧНИЙ УНІВЕРСИТЕТ»

М А Т Е Р І А Л И

105-ї підсумкової науково-практичної конференції
з міжнародною участю
професорсько-викладацького персоналу
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Матеріали підсумкової 105-ї науково-практичної конференції з міжнародною участю професорсько-викладацького персоналу Буковинського державного медичного університету, присвяченої 80-річчю БДМУ (м. Чернівці, 05, 07, 12 лютого 2024 р.) – Чернівці: Медуніверситет, 2024. – 477 с. іл.

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У збірнику представлені матеріали 105-ї підсумкової науково-практичної конференції з міжнародною участю професорсько-викладацького персоналу Буковинського державного медичного університету, присвяченої 80-річчю БДМУ (м. Чернівці, 05, 07, 12 лютого 2024 р.) із стилістикою та орфографією у авторській редакції. Публікації присвячені актуальним проблемам фундаментальної, теоретичної та клінічної медицини.

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into hypothyroidism. Morphological features of the tissue and nodes of the thyroid gland in response to inflammation include increased cell proliferation and growth.

Macroscopically, in the early stages of the disease, the gland is enlarged and has increased blood supply. Hypoplasia of the gland is diagnosed in the later stages. In 10-12% of cases of AIT, there is pronounced atrophy of thyroid follicles and pronounced hyaline fibrosis, the so-called fibrous variant that does not go beyond the gland. Depending on the presence of hyper- and hypofunction of the gland, thyrocytes have different functional activity and morphological characteristics. During histological examination, the tissue of the gland is represented by a micro- and macrofollicular structure with a decrease in colloid production and pronounced lymphoid infiltration of the parenchyma. Thyrocytes in various stages of necrosis are located in the zone of reduced number of follicles. Groups of thyrocytes are located in layers surrounded by macrophages, plasma cells and leukocytes. Hürthle cells are located between layers of thyrocytes with pronounced polymorphism.

The aim of the study. To establish the peculiarities of morphological (cytological) criteria that will allow to improve the differential diagnosis of benign nodes from suspicious and malignant ones.

Material and methods. Ultrasound guided fine needle aspiration biopsy was performed on a 53 nodules of the thyroid gland. Glasses with smears of material from the thyroid gland were taken for examination under a microscope.

Results. Thyroid cells change as a result of acidification of the environment, which occurs in the course of a long-term inflammatory process. While comparing the histological examination of thyroid tissue sections, cells of increased size with acidophilic staining attract special attention. In the literature, they are called Hürthle cells. Their feature is a significant number of mitochondria compared to other cells. The ratio of follicular structures to the stromal component changes towards the stroma. The amount of colloid produced by the gland decreases with a decrease in its concentration. Areas replaced by follicles from the lymphoid tissue generally cease to function as the endocrine gland.

Squamous metaplasia of follicular cells can be observed with a long course of AIT. Other associated features involve mild anisonucleosis, giant cells, histiocytes, scanty colloid, epithelioid cells, plasma cells, focal changes and eosinophils.

Conclusions. The cytological conclusion must be classified according to the categories of the reporting system of cytopathology of nodular formations of the thyroid gland - Bethesda 2017. Against the background of chronic inflammation, the tendency to the formation of malignant tumors is very high. The combination of morphological characteristics, namely pronounced thyrocyte proliferation, nuclear granularity, and nuclear polymorphism in thyroid nodules indicate a high risk of nodule malignancy.

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FETAL ANATOMICAL VARIABILITY OF THE SUPERFICIAL MUSCLES OF THE ANTERIOR CERVICAL REGION

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Introduction. The study of the development and establishment of correlational relationships of organs and structures of the neck in the fetal period of human ontogenesis is caused by the theoretical and practical interest of both morphologists and clinicians to find out the prerequisites for the occurrence of congenital and acquired pathology of muscles, fascial-cellular formations, organs and vascular-nervous structures.

The aim of the study. Identify the anatomical variability of the superficial muscles of the anterior cervical region during the fetal period of human development.

Material and methods. The study was conducted on 75 preparations of human fetuses without external signs of anatomical deviations or developmental anomalies using a complex of morphological research methods.

Results. As a result of the study, additional muscles of the infrahyoid area were found in 6.67% of the fetuses, and fetal anatomical variability of some surface muscles of the neck was established. In a fetus of 196.0 mm TCL, an additional muscle was found – the hyothyroidglandular, which begins with a thin tendon from the body of the hyoid bone, passes through the upper edge of the thyroid cartilage and is attached to the base of the pyramidal lobe of the thyroid gland with a muscle belly. The hyothyroiglandular, muscle is located deeper than the sternohyoid and sternothyroid muscles, but more superficial to the thyrohyoid and cricothyroid muscles. In a fetus of 205.0 mm TCL, the hyothyroidglandular, muscle was found, which starts from the lower edge of the lateral part of the body of the hyoid bone and is attached to the capsule of the left lobe of the thyroid gland, the latter having an inherent crescent shape. The length of this muscle is 3.9 mm, the width in the middle part of the abdomen is 2.6 mm, and the thickness is 0.4 mm. In a fetus of 188.0 mm TCL, the right thyrothyroidglandular muscle was found, which starts from the upper edge of the right plate of the thyroid cartilage and attaches to the capsule of the right lobe of the thyroid gland. In a fetus with 248.0 mm TCL, the left thyrothyroidglandular muscle was also detected, which starts from the outer surface of the left plate of the thyroid cartilage and attaches to the capsule of the left lobe of the thyroid gland. Blood supply to the identified additional muscles is provided by additional branches of the right and left superior thyroid arteries. In one case (fetus 370.0 mm TCL), a tendon membrane was found in the right sternohyoid muscle. The main source of blood supply to the sternohyoid muscle is the superior thyroid artery. The upper and lower thirds of the sternohyoid muscle are best supplied with blood and innervated. As a rule, one nerve enters the sternohyoid muscle at the border of its upper and middle third, and the lower nerve enters the lower third of the muscle. In most cases of observation, the nerves together with the vessels enter through the lateral edge of the middle third of the sternothyroid muscle. The blood supply of the sternothyroid muscle is provided by the branches of the superior and inferior thyroid arteries. The left thyrohyoid muscle was absent in a 240.0 mm TCL fetus. In a fetus of 179.0 mm TCL, the medial and lateral crus of the left sternohyoid muscle were detected; the left thyrohyoid muscle is absent in a 240.0 mm TCL fetus; in the fetus of 310.0 mm TCL the right sternocleidomastoid muscle began with three crura: medial, intermediate and lateral.

Conclusions. In human fetuses, additional muscles and anatomical variability of some superficial muscles of the neck are found. The loose form of the intramuscular branching of the nerves of the ansa cervicalis in the infrahyoid muscles of the neck was established, with the exception of the inferior belly of the omohyoid muscle, where the main form was found. The distribution of nerves in the thickness of the infrahyoid muscles is uneven: the smallest number of nerve branches is found within the middle third of the sternohyoid muscle and the upper third of the sternohyoid muscle. Arteries in the thickness of the infrahyoid muscles mainly branch in the main form.

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ANATOMICAL AND TOPOGRAPHIC CLASSIFICATION OF THE MANDIBULAR CANAL IN CASE OF BONE ATROPHY CAUSED BY THE LOSS OF THE MASTICATORY GROUP OF TEETH FOR PRACTICAL USE

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Introduction. We stated the need to develop a topographic classification of the mandibular canal in edentulous patients for practical use by dentists and expressed our opinion (February 2023) in the materials of the 104th final scientific and practical conference with the international participation of the teaching staff of Bukovinian State Medical University. The loss of teeth leads to disorders of the maxillofacial system, primarily causing bone atrophy, which, by its destructive and morphological changes, affects the anatomical and topographic features of the mandibular canal(s), causing a vector of restrictions in planning the rehabilitation of such patients.

The aim of the study. Based on the identified anatomical variants and our attempt to systematize them, this study aimed to develop an informative anatomical and topographic